

State of Kansas
Kansas Health Policy Authority
Presumptive Disability Medical Team
Landon State Office Building, Room 900 South
900 SW Jackson Street, Topeka, KS 66612
(785) 296-1849
Toll-Free 1-888-547-2763
Fax: (785) 296-1723

ES-3907
10-06

Disability Review Team Referral
Disability Determination Services

| | | | | |
|--|--|--------------|------------------------|-------------------------|
| I. IDENTIFYING INFORMATION: to be completed by KDHE | | | | |
| A. Name (Last, First, MI) | | B. DOB | | C. SSN |
| | | | | |
| D. Address (street, city, zip) | | | | E. Telephone No. |
| | | | | |
| F. Education | G. Gender | H. Race | I Customary Occupation | |
| | | | | |
| J. Currently Employed | | | | K. Case No. |
| YES | | NO | | |
| II. REFERRAL INFORMATION: To be completed by KDHE | | | | |
| A. Application Date | B. Social Security Denial Date Reason | | Verification | C. Onset Date Requested |
| | | | | |
| D. Reconsideration Yes (date) | | No | E. KDHE DE Name | |
| | | | | |
| F. KDHE DE Email | | | | |
| | | | | |
| G. KDHE DE Signature | | | | H. Date |
| | | | | |
| III. Disability Determination Information: To be completed by the DRT | | | | |
| A. Allowed | B. Denied | C. Continued | D. Ceased | E. Onset Date |
| | | | | |
| F. Diagnosis | | | | |
| | | | | |
| | | | | |
| G. Basis for Determination, Treatment, Recommendations and/or Remarks | | | | |
| | | | | |
| | | | | |
| | | | | |
| H. DRT Physician/Phytologist Name and Title: | | | | |
| | | | | |
| I. DRT Physician/Phytologist Signature: | | | | |
| | | | | |